

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03434

03431

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 3 Cherryway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>REED</b> Last <b>BARTLETT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 57</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1876</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b>2</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Conductor-Railroading</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tilghmans Island Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
13. FATHER'S NAME <b>Charles Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>(Ulk)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Doris Brittingham (Niece) R.D.# 3 Cherryway Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident L. with hemi-</b> <b>420.0</b> DUE TO <b>plasia R.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension essential and hypertensive heart disease</b> DUE TO <b>Arteriosclerosis, arterio-sclerotic heart disease</b> (c) <b>Arteriosclerosis, arterio-sclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute cysto-pyelitis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 12, 1957</b> , to <b>March 9, 1957</b> , that I last saw the deceased alive on <b>March 8, 1957</b> , and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. L.V. Sohler</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>303 East St. (Office) Mar. 1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>				M.D. <b>Delmar, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 11 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472

CERTIFICATE OF DEATH

Reg. Dist. No.

03435 337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>1 Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>Levin</b> Middle <b>Thomas</b> Last <b>Beach</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1872</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Sussex County, Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levin Handy Beach</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Bradley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Vernon Beach, Mardela, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Anterior subacute Head Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Sclerostitis - common duct stone</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/1</b> , 19 <b>54</b> to <b>death</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/28</b> , 19 <b>57</b> , and that death occurred at <b>100 Grove St Delmar Del</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4/1/57</b>			
ACTUAL SIGNATURE <b>Ernest M. Larmore</b> M.D.		PHYSICIAN'S NAME (Type) <b>ERNEST M. LARMORE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-2-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Beach</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Marshall - Shapton, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 3 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollaway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MURPHY, JAMES		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1932	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. PLACE OF DEATH Baltimore, Md.		10. DATE OF DEATH April 3, 1967		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF PHYSICIAN J. H. Smith	
13. SIGNATURE OF REGISTRAR J. H. Smith		14. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		15. SIGNATURE OF DECEASED J. H. Smith		16. SIGNATURE OF NEXT OF KIN J. H. Smith	

BUREAU V. S.

APR 3 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03432

## CERTIFICATE OF DEATH

Reg. Dist. No.

03436

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENL Hosp</u>				d. STREET ADDRESS <u>1715 Delaware Ave</u>					
3. NAME OF DECEASED (Type or print) <u>Alice G. Brewington</u>				4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1957</u>					
5. SEX <u>F.M.</u>		6. COLOR OR RACE <u>AA.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-1884</u>			
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>FRED GARFIELD</u>				14. MOTHER'S MAIDEN NAME <u>MARY Shelby</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>_____</u>					
17. INFORMANT <u>Mrs. MAUDE Robinson, Route #2, Salisbury, Md</u>				Address <u>_____</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>260X</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Diabetes Mellitus</u> DUE TO <u>_____</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour a. <u>11</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Nov 1956</u> to <u>Mar 1957</u> , that I last saw the deceased alive on <u>Mar 12 1957</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>652 W Main Salisbury, Md</u> DATE SIGNED <u>Mar 1957</u>									
ACTUAL SIGNATURE <u>F. A. Purnell</u>				M.D. <u>652 W Main Salisbury, Md</u>					
PHYSICIAN'S NAME (Type) <u>F. A. Purnell</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>				ADDRESS <u>Funeral Home, Salisbury, Md</u>					
24a. REC'D BY REGISTRAR <u>Mar 6 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

**BUREAU V. B.**

MAR 6 1957

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03437

## CERTIFICATE OF DEATH

Reg. Dist. No. 33v

1. PLACE OF DEATH COUNTY <b>Wicomico</b> <b>03433</b> <b>MARYLAND</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>16 yrs</b> TOWN <b>Salisbury</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Wicomico</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> TOWN <b>Salisbury</b> STREET ADDRESS (If rural give location) <b>Lemon Hill</b>			
3. NAME OF DECEASED (Type or Print) <b>SENORA</b> <b>BELLE</b> <b>BROWN</b>				4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>26th</b> (Year) <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>February 3, 1872</b>	9. AGE last birthday <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Anthony Brown</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Malone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Records: John B. Parsons Home Salisbury, Maryland</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <b>Cardiovascular renal disease</b> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 <b>57</b> , to <b>3-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-27</b> , 19 <b>57</b> , and that death occurred at <b>4:00A.M.</b> from the causes and on the date stated above. SIGNATURE <b>Philip A. Insley</b> ADDRESS (Street, city, town, state) <b>M.D. E. Main St. Salisbury, Maryland</b> DATE SIGNED <b>Mar. 28 / 57</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Mar. 28, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Smullen Cemetery</b>		LOCATION (City, town, or county) (State) <b>Worcester Co. Maryland</b>	
24. REC'D BY REGISTRAR <b>APR 1 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 3

APR 1 1957

RECEIVED



03473

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b>				c. LENGTH OF STAY IN 1b <b>app: 15yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 (Rural)</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b>			
f. STREET ADDRESS <b>1 R.D.# 1 (Rural)</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ADDIE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1872</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (State or foreign country) <b>Rogersville, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>(UNK)</b>				14. MOTHER'S MAIDEN NAME <b>(UNK)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mr. Byras V. Cook (Son) R.D.# 1 (Rural) Quantico, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 5<sup>th</sup>, 1957</b> , to <b>March 5<sup>th</sup>, 1957</b> , that I last saw the deceased alive on <b>March 5<sup>th</sup>, 1957</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Eurich</b>				ADDRESS (Street, city or town, state) <b>Main St. (Office) March 5<sup>th</sup> 1957</b>			
DATE SIGNED <b>March 5<sup>th</sup> 1957</b>							
PHYSICIAN'S NAME (Type) <b>Dr. William Eurich</b>				M.D. <b>Hebron, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 8 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 8 1957

RECEIVED

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,9 FilmG212 3-20-57 et

CERTIFICATE OF DEATH

03434

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>7 Mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>732 Jackson St., Private Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Vernon 19x12</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLYDE MARTIN COSTEN</b>				4. DATE OF DEATH Month Day Year <b>3 5 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1887</b>		9. AGE (In years last birthday) <b>67 69 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry T. Costen</b>				14. MOTHER'S MAIDEN NAME <b>Lula Brewington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>Mrs. Joseph Lappin, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>163X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Less than 1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-3</b> , 19 <b>57</b> , to <b>3-5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-5</b> , 19 <b>57</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilber R. Ellis, Jr.</b>		M.D. <b>Medical Center, Salisbury, Md. 3/6/57</b>					
PHYSICIAN'S NAME (Type) <b>Wilber R. Ellis, Jr. M.D.</b>		<b>Medical Center, Salisbury, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>3-7-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary M. Holloman</b>	

Norman T. Baker

BUREAU V. S.

MAR 11 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03474

## CERTIFICATE OF DEATH

03440

332

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXX</b>				d. STREET ADDRESS <b>XXX</b>			
3. NAME OF DECEASED (Type or print) <b>LEVIN T. DAVIS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1870</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas J. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Godfrey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>X</b>		16. SOCIAL SECURITY NO. <b>X</b>		17. INFORMANT <b>Mr. Elmer C. Davis</b>		Address <b>Willards, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>9.11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3-7</b> , 19 <b>57</b> , to <b>3-7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-7</b> , 19 <b>57</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Lewis</b>				ADDRESS (Street, city or town, state) <b>Willards Maryland</b>			
PHYSICIAN'S NAME (Type) <b>FRANK LEWIS</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dennis</b>		22d. LOCATION (City, town, or county) (State) <b>Willards Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Selbyville Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. 5.**

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, if filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film 0213 1-1-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03435		03441 337	
1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop 23X12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Bishop 23X12</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert SAMUEL DAVIS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 24 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7, 1987</u>
9. AGE (In years lost birthday) yrs. <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BISHOPS, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HIRAM BURTON DAVIS</u>	
14. MOTHER'S MAIDEN NAME <u>ANNIE K. BAKER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>221-12-0271</u>		17. INFORMANT Address <u>MR. M. P. DAVIS BERLIN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-21</u> , 19 <u>57</u> , to <u>3-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-24-57</u> , 19 <u>57</u> , and that death occurred at <u>10:59 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Schure</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. March 24, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Diana A. Gurbay</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>MAR 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Hallaway</u>	

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
HOSPITAL		HOSPITAL	
DATE OF BIRTH		DATE OF DEATH	
AGE		AGE	
SEX		SEX	
RACE		RACE	
MARRIAGE		MARRIAGE	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		DATE OF REGISTRATION	
PLACE OF REGISTRATION		PLACE OF REGISTRATION	
OFFICIAL USE		OFFICIAL USE	

BUREAU V. B.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

03475

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		c. LENGTH OF STAY IN 1b <u>5 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>404 East Street</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>05X22 Denton</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Brewster Deen</u>		4. DATE OF DEATH Month Day Year <u>March 12 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney at Law</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Deen</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Willis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, age, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Victoria D. Butler, Delmar, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis L. hemisphere</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral and generalized arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Skin Cancer L. lower eyelid</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1956</u> , to <u>March 12, 1957</u> , that I last saw the deceased alive on <u>March 12, 1957</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.V. Sohler</u>		M.D. <u>303 East Street Delmar</u> DATE SIGNED <u>3-14-57</u>	
PHYSICIAN'S NAME (Type) <u>L.V. Sohler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 15, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>3-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED		2. SEX		3. RACE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		White		1910		Maryland	
6. CITY OF DEATH		7. COUNTY OF DEATH		8. STATE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
Baltimore		Baltimore		Maryland		1957		10:00 AM	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. SIGNATURE OF DECEASED		15. SIGNATURE OF WITNESS	
Heart Disease		Natural		Home					
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESS		25. SIGNATURE OF DECEASED	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESS		35. SIGNATURE OF DECEASED	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESS		38. SIGNATURE OF DECEASED		39. SIGNATURE OF WITNESS		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESS		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF DECEASED		49. SIGNATURE OF WITNESS		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS		55. SIGNATURE OF DECEASED	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESS		58. SIGNATURE OF DECEASED		59. SIGNATURE OF WITNESS		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF DECEASED		64. SIGNATURE OF WITNESS		65. SIGNATURE OF DECEASED	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESS		68. SIGNATURE OF DECEASED		69. SIGNATURE OF WITNESS		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS		73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF DECEASED		79. SIGNATURE OF WITNESS		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF DECEASED		84. SIGNATURE OF WITNESS		85. SIGNATURE OF DECEASED	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESS		88. SIGNATURE OF DECEASED		89. SIGNATURE OF WITNESS		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS		95. SIGNATURE OF DECEASED	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESS		98. SIGNATURE OF DECEASED		99. SIGNATURE OF WITNESS		100. SIGNATURE OF DECEASED	

**RECEIVED**  
 MAR 26 1957  
 BUREAU V. 5



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03443

03476

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Main St</b>				d. STREET ADDRESS <b>Main St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>GRANT</b> Last <b>DENNIS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26th</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1903</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Willards Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Grant Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Bettie Burbage</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Bessie D. Dennis (Wife) Main St. Willards, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound of heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <b>Self inflicted bullet wound.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>12:30 P.M.</b> <b>3-26-19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Garage at home.</b>		20f. (City or town) (County) (State) <b>Willards Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DENNIS FAMILY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>Mar 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF DEPUTY ATTORNEY GENERAL	

BUREAU V. S.

MAR 29 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>In Village</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>EMILY</b> Last <b>DERICKSON</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1898</b>		9. AGE (In years last birthday) <b>58</b> yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Allison T. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Annie Elliott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mr. William H. Derickson (Husband)</b>				Address <b>In Village Parsonsborg, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic congestive heart failure</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Nov. 54</b> , 19____, to <b>3-2057</b> , 19____, that I last saw the deceased alive on <b>3-19-57</b> , 19____, and that death occurred at <b>A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Camden Ave. (Office)</b> DATE SIGNED <b>March 21 1957</b> ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b> <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsborg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parsonsborg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03436

CERTIFICATE OF DEATH

03445

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>46 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield 19-39-2</b>		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>W. Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ira</b> Middle <b>Dorman</b> Last <b>Dize</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 11 1899</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Seyvern Dize</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dorman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 31, 1957</b> , to <b>March 18, 1957</b> , that I last saw the deceased alive on <b>March 18, 1957</b> , and that death occurred at <b>10:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andres Grisolia</b> M.D.		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Andres Grisolia, M. D.</b>		DATE SIGNED <b>3/19/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield, Cemebery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dono H. Carville</b>		ADDRESS <b>Baltimore Funeral Home</b>	
24a. REC'D BY REGISTRAR <b>DATE 3-26-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03478

## CERTIFICATE OF DEATH

03446

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Fruitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>CATHELL</u> Last <u>DULANY</u>				4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1865</u>		9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George W. Cathell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Carey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mr. Ralph O. Dulany, Fruitland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.1</u> DUE TO <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 30</u> , 19 <u>50</u> , to <u>March 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>						DATE SIGNED <u>3/25/57</u>	
ACTUAL SIGNATURE <u>David H. Gilmore</u> M.D.							
PHYSICIAN'S NAME (Type) <u>David H. Gilmore M.D. Medical Center, Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill &amp; Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 3-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03437

CERTIFICATE OF DEATH

03447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>2yrs 10mo. 14</b>		d. STREET ADDRESS <b>819 Roselin Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Dunn</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1869</b>
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Dunn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Calloway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>?</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 24, 19 54</b> , to <b>Mar. 10, 19 57</b> , that I last saw the deceased alive on <b>Mar. 10, 19 57</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andres Grisolia</b> M.D.		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>3/10/57</b>	
PHYSICIAN'S NAME (Type) <b>Andres Grisolia, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 12, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Md</b>	
24a. REC'D BY REGISTRAR <b>3/11/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary D. Calloway</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "March 10, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BURIAL [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint number]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	

BUREAU V. R.

MAR 13 1957

RECEIVED



03479

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 1</b>		d. STREET ADDRESS <b>RFD # 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Alice</b> Last <b>Evans</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>2nd</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Whitesville, Del</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harvey Brittingham</b>		14. MOTHER'S MAIDEN NAME <b>Lovey Foskey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Leslie Evans, Delmar, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Heart Disease</b> (c) <b>5 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/2</b> , 19 <b>56</b> , to <b>death</b> , 19 <b>57</b> , that I lost saw the deceased olive on <b>Mar 1</b> , 19 <b>57</b> , and that death occurred at <b>2A</b> M, from the causes on and on the date stated above.			
ACTUAL SIGNATURE <b>Ernest Larmore</b> M.D.		ADDRESS (Street, city or town, state) <b>Delmar, Del</b>	
PHYSICIAN'S NAME (Type) <b>ERNEST LARMORE</b>		DATE, SIGNED <b>3/3/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Line</b>		22d. LOCATION (City, town, or county) (State) <b>Whitesville, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Gorman Co - Delmar, Del</b>		24a. REC'D BY REGISTRAR <b>DATE 5 1957</b>	
ADDRESS <b>Delmar, Del</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death 1957-03-05		Place of Death Baltimore	
Name of Deceased LEO V. KENNY		Sex Male	
Date of Birth 1-27-1898		Race White	
Usual Residence Baltimore		Cause of Death Heart Disease	
Place of Birth Baltimore		Duration of Illness 10 days	
Name of Physician Dr. LEO V. KENNY		Name of Hospital St. Joseph's Hospital	
Name of Informant LEO V. KENNY		Name of Registrar LEO V. KENNY	
Signature of Informant LEO V. KENNY		Signature of Registrar LEO V. KENNY	

BUREAU V. S.

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03438

## CERTIFICATE OF DEATH

Reg. Dist. No.

03449  
332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON 23X02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>STOCKTON 23X02</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First Middle Last <u>Fetkenher</u>		4. DATE OF DEATH <u>MARCH</u> 29 1957	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1904</u>
9. AGE in years <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator, Roadwork Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Fetkenher</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Pederhoff</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Busch, Selton, Dela</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis (abdominal)</u> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-7</u> , 19 <u>57</u> , to <u>3-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/29/57</u> , and that death occurred at <u>3-29</u> , 19 <u>57</u> , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David Hilborn</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. March 29, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE	

**BUREAU V. S.**

APR 3 1957

RECEIVED

## 03439 CERTIFICATE OF DEATH

Reg. Dist. No.

33v

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>LEE</b> Last <b>FOXWELL</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>th 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1934</b>		9. AGE (In years last birthday) <b>22</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Employee of Fuller Brush Co., R.D.# 1 Salisbury, Md.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Richard G. Foxwell</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Elizabeth V. Foxwell (Wife) R.D.# 3 Delmar Md.</b> <b>Mr. Richard G. Foxwell (Father) Camden Ave. Ext.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis &amp; Coma</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>1954</b> , to <b>3-15-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-15-57</b> , 19 <b>57</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lee L. Lawry</b> M.D.				ADDRESS (Street, city or town, state) <b>Fruitland, Maryland</b> DATE SIGNED <b>Mar. 17, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 21 1957</b>		24b. REGISTRAR'S SIGNATURE <i>May H. Holloway</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX (Male or Female)		AGE (In years, months, and days)	
PLACE OF BIRTH (City, State, and Country)		OCCUPATION (If any)		CAUSE OF DEATH (If known)	
DATE OF DEATH (Month, day, and year)		TIME OF DEATH (If known)		PLACE OF DEATH (If known)	
NAME OF PHYSICIAN (If known)		NAME OF NURSE (If known)		NAME OF MINISTER (If known)	
NAME OF FUNERAL HOME (If known)		NAME OF BURIAL PLACE (If known)		NAME OF CEMETERY (If known)	
NAME OF NEXT OF KIN (If known)		NAME OF SURVIVOR (If known)		NAME OF WITNESS (If known)	
NAME OF REGISTRAR (If known)		NAME OF CLERK (If known)		NAME OF ASSISTANT (If known)	
NAME OF DECEASED (Print name in full)		SEX (Male or Female)		AGE (In years, months, and days)	
PLACE OF BIRTH (City, State, and Country)		OCCUPATION (If any)		CAUSE OF DEATH (If known)	
DATE OF DEATH (Month, day, and year)		TIME OF DEATH (If known)		PLACE OF DEATH (If known)	
NAME OF PHYSICIAN (If known)		NAME OF NURSE (If known)		NAME OF MINISTER (If known)	
NAME OF FUNERAL HOME (If known)		NAME OF BURIAL PLACE (If known)		NAME OF CEMETERY (If known)	
NAME OF NEXT OF KIN (If known)		NAME OF SURVIVOR (If known)		NAME OF WITNESS (If known)	
NAME OF REGISTRAR (If known)		NAME OF CLERK (If known)		NAME OF ASSISTANT (If known)	

BUREAU V. 8

MAR 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03451

03440

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>29x22</u> HURLOCK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsular General Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>SARAH Ida</u> First Middle Last <u>Hambull</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 20, 1862</u>	
9. AGE (In years lost birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CAROLINE CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>PERRY D. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH (MAIDEN NAME UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. CARL L. PUSEY, SALISBURY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u> DUE TO <u>170x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Following Surgery for Carcinoma of Breast</u> (c) <u>(Infiltrating Breast Carcinoma 2 Abscesses.)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3-10</u> , 19 <u>57</u> , to <u>3-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>57</u> , and that death occurred at <u>4:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hunter R. Mann Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>209 Maryland Ave, Salisbury, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Hunter R. Mann Jr.</u>				DATE SIGNED <u>3-17-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HURLOCK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. FRAMPTON AND SON, FEDERALSBURG, MD</u>				24a. RECE'D BY REGISTRAR <u>3-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Maryell Holladay</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4 1968		MEMPHIS, TENN.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH	
MARRIED		APR 1964		MEMPHIS, TENN.		APR 1933		MEMPHIS, TENN.		APR 4 1968	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
MEMBER OF ARMY		APR 1964		MEMPHIS, TENN.		APR 1968		MEMPHIS, TENN.		APR 4 1968	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SHOOTING		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
HOMICIDE		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
JAMES EARL RAY		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
JAMES EARL RAY		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968	

RECEIVED  
MAR 28 1967  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG212 3-20-57 at

03452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Pittsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In Village</b>		d. STREET ADDRESS <b>/ In Village</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>VIRGINIA</b> Last <b>GORDY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12th</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1917</b>
9. AGE (In years last birthday) <b>38 39 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Seaford Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John C. Bozman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Ralph E. Gordy (Husband)</b> <b>Pittsville, Maryland</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		DATE SIGNED <b>March 14 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 16, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24. REG'D BY REGISTRAR <b>March 15 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

BUREAU V. S.

MAR 15 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal.

VS. A15ME(5)  
5M 9/55

BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03453
03441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 332
Item 7 Film G213 4-3-57 et										
1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> <u>Somerset</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> <u>19x0.2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Gordy</u> Last <u>Gordy</u>					4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>19 57</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>73</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Daniel Gordy</u>					14. MOTHER'S MAIDEN NAME <u>Lira Robertson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to carbon monoxide poisoning.</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Second and third degree burns of face and hands</u> DUE TO (c) <u>35 minutes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased was paralyzed and trapped in house when stove exploded</u>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>8:05</u> a. m. <u>3-22-57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Westover</u>		20g. (County) <u>Wicomico</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Earl L. Royer</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>3-24-57</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Revell Neck, Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>					24a. REC'D BY REGISTRAR DATE <u>3-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank, with some faint markings and checkboxes.

BUREAU V. S.

MAR 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

## CERTIFICATE OF DEATH

Reg. Dist. No.

03454

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>1 206 Marshall St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAE</b> Middle <b>DENNIS</b> Last <b>HANCOCK</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>22nd</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1886</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>6</b> Days <b>1</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee Shirt Factory (Operator)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Operator)</b>	
11. BIRTHPLACE (State or foreign country) <b>Near Whiton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Phillip Dennis</b>		14. MOTHER'S MAIDEN NAME <b>Annie Haddock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Calvin J. Hancock (Son)</b>		Address <b>904 Spring Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>degenerative heart disease</b> DUE TO <b>3 yrs.</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/54</b> , 19 <b>54</b> , to <b>3/22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/22</b> , 19 <b>57</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md</b> DATE SIGNED <b>3/22/57</b> ACTUAL SIGNATURE <b>Carl M. Beardsley</b> M.D. <b>Salisbury, Md</b> PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b> <b>Salisbury, Maryland</b> <b>March 22, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 25, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Walston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD</b>		24a. REC'D BY REGISTRAR <b>MAR 27 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03443

CERTIFICATE OF DEATH

03455

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 yrs. 10 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>McKinney</b> Last <b>Hawk</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11,</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 5, 1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Nelson Hawk</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Catherine Harner</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>			
16. SOCIAL SECURITY NO. <b>--</b>				17. INFORMANT Address <b>Deer's Head Hospital, Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>disease</b> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury, Maryland</b>				20g. (County) <b>Carroll</b>			
20h. (State) <b>Maryland</b>				20i. (City or town) <b>Salisbury, Maryland</b>			
21. I certify that I attended the deceased from <b>April 13, 19 53</b> , to <b>March 11, 19 57</b> , that I last saw the deceased alive on <b>March 11, 19 57</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andres Grisolia</b> M.D.				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital, Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Andres Grisolia</b>				DATE SIGNED <b>3/11/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Carroll, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b>				ADDRESS <b>Taneytown, Maryland</b>			
24a. REC'D BY REGISTRAR <b>MAR 13 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			



BUREAU V. S.

MAR 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03456

03481

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>78 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>704 East Street</b>				d. STREET ADDRESS <b>704 East Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph William Hearn</b>				4. DATE OF DEATH Month Day Year <b>Mar. 9th 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1878</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postal Employee, Post Office</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Delmar, Del.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Martin Hearn</b>				14. MOTHER'S MAIDEN NAME <b>Theodosia LeCates</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>221-10-5706</b>		17. INFORMANT <b>J. Elton Hearn, Delmar, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis with Angina attack</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>for 2 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 20</b> , 19 <b>57</b> , to <b>Feb 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 8</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. H. Lynd</b>				ADDRESS (Street, city or town, state) <b>Delmar, Del</b>			
PHYSICIAN'S NAME (Type) <b>L. H. Lynd</b>				DATE SIGNED <b>Mar 14 '57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Marvel Co - Delmar, Del</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 14 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

CERTIFICATE OF DEATH

Name of Deceased John Doe		Sex Male		Age 45		Date of Birth Jan 1, 1912	
Place of Birth Baltimore, Md.		Race White		Marital Status Married		Occupation Teacher	
Cause of Death Heart Disease		Immediate Cause Myocardial Infarction		Underlying Cause Coronary Artery Disease		Manner of Death Natural	
Date of Death Mar 10, 1957		Time of Death 10:00 AM		Place of Death Home		Physician's Name Dr. J. K. Smith	
Signature of Physician J. K. Smith		Signature of Registrar M. A. Jones		Signature of Informant John Doe		Signature of Deceased John Doe	
Date of Signature Mar 11, 1957		Date of Signature Mar 11, 1957		Date of Signature Mar 11, 1957		Date of Signature Mar 11, 1957	

BUREAU A. B.

MAR 14 1957

RECEIVED

03444

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke 23-42-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>203 BONNEVILLE AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>EULALIA</u> First Middle Last		4. DATE OF DEATH <u>MARCH 11</u> 19 <u>57</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24/1877</u> 9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pocomock</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John William McIner</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-9</u> , 19 <u>57</u> , to <u>3/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>3/12/57</u>	<u>Edgemoor</u>	<u>Pocomoke</u> Va
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
<u>Robert W. Lichten</u>		<u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





03445

## CERTIFICATE OF DEATH

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke 23-42-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>7 Clarke Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>M.</u> Last <u>Hitchens</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 23, 1893</u>		9. AGE (In years last birthday) <u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS A. GERMAN</u>				14. MOTHER'S MAIDEN NAME <u>OLIVIA BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-22-4687</u>		17. INFORMANT Address <u>FORD D. HITCHENS, JR., POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3-4</u> , 19 <u>57</u> to <u>3-13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-13</u> , 19 <u>57</u> , and that death occurred at <u>4:15 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>3-13-57</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GROTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HALLWOOD, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR <u>MAR 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary K. Followay</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>All his life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jrome Z Holland</b>				4. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/16/1905</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Packing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Irvin Holland</b>				14. MOTHER'S MAIDEN NAME <b>Annie Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XXXXXXXX</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 12 6812</b>		17. INFORMANT <b>Mrs. Susan Hymen, Sp Hill Rd, Salisbury, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung cancer</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Lung abscess</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1957</b> , to <b>March 14, 1957</b> , that I last saw the deceased alive on <b>March 17, 1957</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>303 East Street, Delmar 316-57</b> DATE SIGNED <b>March 20 1957</b>							
ACTUAL SIGNATURE <b>L. V. Schler</b> M.D.				PHYSICIAN'S NAME (Type) <b>L. V. Schler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acre Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart</b>				ADDRESS <b>Funeral Home, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>Mary H. Holloway</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03460

03432

## CERTIFICATE OF DEATH

Reg. Dist. No.

33✓

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>		c. LENGTH OF STAY IN 1b <b>6 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Mardela Rural</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 (Athol Road)</b>	
d. STREET ADDRESS <b>/ R.D.# 1 (Athol Road)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(ALEX) ALEXANDER WASHINGTON HOPKINS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1867</b>
9. AGE (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joshua James Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. James W. Hopkins (Son)</b>	
17. INFORMANT <b>Mr. James W. Hopkins (Son)</b>		Address <b>R.D.# 1 (Athol Road) Mardela, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 4, 1957</b> , to <b>March 13, 1957</b> , that I last saw the deceased alive on <b>March 13, 1957</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William E. Enrich</b> M.D. <b>Main St. (Office)</b>		DATE SIGNED <b>March 4 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. William Enrich</b> M.D. <b>Hebron, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 6, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>MAR 7 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			



MAR 7 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03447

CERTIFICATE OF DEATH

03461

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>Carey Ave. R.D.# 3</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>ELLEN</b> Last <b>HUMPHREYS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>14th</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1903</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>23</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work - Shirt Factory Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Hastings</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Jenkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-6482</b>	
17. INFORMANT Address <b>Mrs. Harry Austin (Daughter) R.D.#3 Carey Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>199.9</b> DUE TO <b>MASSIVE LUNG CANCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DISSEMINATED CERVICAL CANCER</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/18/56</b> , 19 <b>56</b> , to <b>3/14</b> , 19 <b>57</b> that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>7:15P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Andrew C. Mitchell</b>		ADDRESS (Street, city or town, state) <b>Maryland Ave. (Office) Mar. 15 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. O.J. Burton</b>		DATE SIGNED <b>Mar. 15 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 17, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>18 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>		4. DATE OF DEATH <u>MAR 18 1957</u>	
5. PLACE OF DEATH <u>HOME</u>		6. STREET <u>1234 E. BALTIMORE ST.</u>		7. CITY <u>BALTIMORE</u>		8. STATE <u>MD</u>	
9. OCCUPATION <u>CLERK</u>		10. MARITAL STATUS <u>MARRIED</u>		11. NUMBER OF DEPENDENTS <u>2</u>		12. CAUSE OF DEATH <u>HEART DISEASE</u>	
13. MEDICAL HISTORY <u>NO</u>		14. PRESENT ILLNESS <u>NO</u>		15. DATE OF ONSET <u>NO</u>		16. DATE OF DEATH <u>NO</u>	
17. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		18. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		19. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		20. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
21. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		22. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		23. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		24. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
25. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		26. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		27. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		28. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
29. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		30. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		31. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		32. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
33. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		34. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		35. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		36. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
37. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		38. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		39. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		40. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
41. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		42. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		43. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		44. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
45. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		46. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		47. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		48. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
49. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		50. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		51. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		52. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
53. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		54. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		55. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		56. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
57. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		58. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		59. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		60. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
61. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		62. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		63. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		64. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
65. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		66. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		67. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		68. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
69. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		70. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		71. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		72. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
73. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		74. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		75. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		76. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
77. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		78. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		79. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		80. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
81. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		82. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		83. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		84. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
85. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		86. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		87. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		88. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
89. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		90. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		91. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		92. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
93. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		94. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		95. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		96. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
97. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		98. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		99. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		100. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	

BUREAU V. S.

MAR 18 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Surrey</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar 46X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>200 Grove</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Jackson</u>				4. DATE OF DEATH Month Day Year <u>3-12-1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-11-1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Kloran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>189-056193</u>		17. INFORMANT Address <u>Josephine Jackson Delmar, Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat. while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 3, 1957</u> to <u>March 12, 1957</u> that I last saw the deceased alive on <u>March 12, 1957</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Mary H. Holloway</u>				M.D. <u>Salisbury Md March 12, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24. RECORD BY REGISTRAR			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 15 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BELLINGHAM 10



03449

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> R.R.#1.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>46X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Phillip</u> <u>1</u> <u>JAMES</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>8</u> <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 11, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Reuben James</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE SHORT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MRS. FANNIE SHORT, SEAFORD, DEL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral 7 lines &amp; Carotid artery 3 months</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-6</u> , 19 <u>57</u> , to <u>3-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>57</u> , and that death occurred at <u>10:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. H. M.D.</u>				ADDRESS (Street, city or town, state) <u>Laurel, Delaware</u>			
DATE SIGNED <u>Mar 11 1957</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAUREL HILL Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H.</u>				ADDRESS <u>Laurel, Delaware</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallways</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF THE GOSPEL		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF CREMATION		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
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73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

BUREAU V. 3

MAR 11 1957

RECEIVED

03450

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 732 JACKSON STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM Thomas JAMES IV</u>				4. DATE OF DEATH Month Day Year <u>MARCH 15 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>William T. James III</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Wm. T. James III, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, acute</u> <u>752 Secondary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) <u>Severe dehydration + acidosis</u> DUE TO lying down (b) <u>Hydrocephalus, Congenital</u> DUE TO lying down (c) <u>Menigecele with paralysis of lower ext.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>48 hrs</u> <u>9 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Menigecele with paralysis of lower ext.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 14</u> , 19 <u>57</u> , to <u>Mar 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 15</u> , 19 <u>57</u> , and that death occurred at <u>10.00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.W. Saunderson Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>926 N. Division St. Salisbury Md. 3/15/57</u>			
PHYSICIAN'S NAME (Type) <u>R.W. Saunderson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Epic. Chruchyard</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>				24a. REC'D BY REGISTRAR DATE <u>3-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>	

## MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

19

11.

MAR 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03465327

03451

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nannie E. Jarrell</b>				4. DATE OF DEATH Month Day Year <b>3-4-57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1866</b>	
9. AGE (In years last birthday) <b>90 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline C. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>							
13. FATHER'S NAME <b>Hugh Duffey</b>				14. MOTHER'S MAIDEN NAME <b>Catherine See</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Joseph M. Eaton, Hillsboro</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1953</b> to <b>March 4, 1957</b> that I last saw the deceased alive on <b>3-3</b> , 19 <b>57</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Tusley</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>			
DATE SIGNED <b>3/4/57</b>							
PHYSICIAN'S NAME (Type) <b>Philip A. Tusley</b>				<b>SALISBURY MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount.</b>		22d. LOCATION (City, town, or county) (State) <b>Hillsboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward M. Eaton</b>				24a. REC'D BY REGISTRAR <b>Edward M. Eaton</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03452

## CERTIFICATE OF DEATH

03466

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-POCOMOKE CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peppersburg General Hospital</u>				d. STREET ADDRESS <u>Box 81 23X22</u>			
3. NAME OF DECEASED (Type or print) <u>Charles F. Justice</u>				4. DATE OF DEATH <u>March 9 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 14, 1889</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE STATION ATTENDANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. JUSTICE</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE DIX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-26-8450</u>			
17. INFORMANT <u>MRS ANNIE E. JONES</u>				Address <u>STOCKTON MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>January 1, 1957</u> , to <u>March 9, 1957</u> , that I last saw the deceased alive on <u>March 9, 1957</u> , and that death occurred at <u>4:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>William S. Ellis, Jr.</u> M.D. _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BRITTINGHAM CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL POCOMOKE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>POCOMOKE, MD.</u>		24a. RECD BY REGISTRAR <u>MARY H. FELLOWAY</u>	
				DATE <u>MAR 13 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCASION OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF CORONER [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]		15. SIGNATURE OF OTHER [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF OTHER [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]		21. SIGNATURE OF OTHER [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF NEXT OF KIN [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF NEXT OF KIN [Faint text]		27. SIGNATURE OF OTHER [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF NEXT OF KIN [Faint text]		30. SIGNATURE OF OTHER [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF NEXT OF KIN [Faint text]		33. SIGNATURE OF OTHER [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF NEXT OF KIN [Faint text]		36. SIGNATURE OF OTHER [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF NEXT OF KIN [Faint text]		39. SIGNATURE OF OTHER [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF NEXT OF KIN [Faint text]		42. SIGNATURE OF OTHER [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF NEXT OF KIN [Faint text]		45. SIGNATURE OF OTHER [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF NEXT OF KIN [Faint text]		48. SIGNATURE OF OTHER [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF NEXT OF KIN [Faint text]		51. SIGNATURE OF OTHER [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF NEXT OF KIN [Faint text]		54. SIGNATURE OF OTHER [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF NEXT OF KIN [Faint text]		57. SIGNATURE OF OTHER [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF NEXT OF KIN [Faint text]		60. SIGNATURE OF OTHER [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF NEXT OF KIN [Faint text]		63. SIGNATURE OF OTHER [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF NEXT OF KIN [Faint text]		66. SIGNATURE OF OTHER [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF NEXT OF KIN [Faint text]		69. SIGNATURE OF OTHER [Faint text]	
70. SIGNATURE OF DECEASED [Faint text]		71. SIGNATURE OF NEXT OF KIN [Faint text]		72. SIGNATURE OF OTHER [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF NEXT OF KIN [Faint text]		75. SIGNATURE OF OTHER [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF NEXT OF KIN [Faint text]		78. SIGNATURE OF OTHER [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF NEXT OF KIN [Faint text]		81. SIGNATURE OF OTHER [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF NEXT OF KIN [Faint text]		84. SIGNATURE OF OTHER [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF NEXT OF KIN [Faint text]		87. SIGNATURE OF OTHER [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF NEXT OF KIN [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF NEXT OF KIN [Faint text]		93. SIGNATURE OF OTHER [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF NEXT OF KIN [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF NEXT OF KIN [Faint text]		99. SIGNATURE OF OTHER [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF NEXT OF KIN [Faint text]		102. SIGNATURE OF OTHER [Faint text]	

BUREAU V. S.

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03453

## CERTIFICATE OF DEATH

03467

Reg. Dist. No.

33v

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>214 West Locust St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (BABY) First <b>STARR</b> Middle <b>LYNN</b> Last <b>LARMORE</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>18th</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1957</b>		9. AGE (In years last birthday) yrs. <b>0</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Raymond Max Larmore</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Meredith Budd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Raymond Max Larmore (Father) 214 West Locust St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure - congenital microcephaly, cyclops deformity and absence of nose</b> <b>759.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3/18</b> , 19 <b>57</b> , to <b>Mar. 18th</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Mar. 18th</b> , 19 <b>57</b> , and that death occurred at <b>2:30 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delmar, Delaware</b> DATE SIGNED <b>March 18, 1957</b>							
ACTUAL SIGNATURE <b>Ernest M. Larmore</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. E.M. Larmore</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bivalve Meth Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bivalve, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

2082325 XV5





03483

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Eden Rt 2</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>May</u> Middle <u>Leatherbury</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F.M.</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/16/1905</u>	
9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Stephen Jones</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Tull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>*****</u>				16. SOCIAL SECURITY NO. <u>*****</u>		17. INFORMANT <u>William Leatherbury, Eden, Md. Rt#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 Mos.</u> <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. <u>  </u> p. <u>  </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1 Feb</u> , 19 <u>56</u> , to <u>8 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 March</u> , 19 <u>57</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Purnell</u>				ADDRESS (Street, city or town, state) <u>652 W. Main St., Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Purnell, M.D.</u>				DATE SIGNED <u>8 March 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/11/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Polks Road, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## A KENTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

MAR 14 1957

RECEIVED

# STATE OF MARYLAND—BALTIMORE, 18

03451

Item 9 Film 212 3-11-57 et

## CERTIFICATE OF DEATH

03469

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>104 W. Vine St</b>				d. STREET ADDRESS <b>104 W. Vine St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>First WILLIAM Middle HANDY Last LIVINGSTON</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>1st</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1871</b>	9. AGE (In years last birthday) <b>86 85 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Benjamin Peter Livingston</b>				14. MOTHER'S MAIDEN NAME <b>Martha Carey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. William M. Livingston (Son)</b> Address <b>202 Holland Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>332X</b> DUE TO <b>ATHEROSCLEROSIS &amp; HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>24 hrs.</b> (c) <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONGESTIVE CARDIAC FAILURE.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 7, 1953</b> , to <b>2/11, 1957</b> , that I last saw the deceased alive on <b>2/28, 1957</b> , and that death occurred at <b>5:00A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Maryland Ave.</b>				DATE SIGNED <b>Mar. 1 1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. O.J. Burton</b> M.D. <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME—SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 4 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary T. Holloway</b>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy **may** be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03455

## CERTIFICATE OF DEATH

03470

237

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 5/11/56</u>		STREET ADDRESS (If rural give location) <u>RED #2 Spring Hill Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Herbert Wilson Lowe, Sr.</u>				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>23</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 7, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Samuel Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Ida Isabella Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient when admitted to hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
002X IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>						1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 11</u> <u>19 56</u> , <b>to</b> <u>March 23</u> <u>19 57</u> , <b>that I last saw the deceased alive on</b> <u>March 23</u> <u>19 57</u> , <b>and that death occurred at</b> <u>6:40aM</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>[Signature]</u> <b>M.D.</b> <u>Salisbury, Maryland</u> <b>DATE SIGNED</b> <u>3/23/57</u> <b>ADDRESS</b> (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 26 57</u>		NAME OF CEMETERY OR CREMATORY <u>McComie Mem. Park</u>		LOCATION (City, town, or county) <u>Salisbury Md.</u> (State)	
24. REC'D BY REGISTRAR <u>MARY 27 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway &amp; Co. Salisbury Md.</u>		ADDRESS	
DATE							



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03471

Reg. Dist. No.

337

03484

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs</b>				c. LENGTH OF STAY IN 1b <b>3 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Lowe</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 29, 1870</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fish</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Isaac Lowe</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>L. Fulton Lowe, Sharptown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Mar 20</b> , 19 <b>57</b> , to <b>Mar 22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Mar 22</b> , 19 <b>57</b> , and that death occurred at <b>8:50</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kuhlman</b>				ADDRESS (Street, city or town, state) <b>Sharptown Md</b>		DATE SIGNED <b>3/23/57</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-24-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Karl W. Hamel-Sharptown, Md</b>				ADDRESS <b>Sharptown, Md</b>		24a. REC'D BY REGISTRAR <b>Mary Holloway</b>	
24b. REGISTRAR'S SIGNATURE							

CERTIFICATE OF DEATH

Reg. No. 114

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15, 1910		New York City		New York City		Heart Disease		Jan 20, 1957		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Last Medical Examination		Last Medical Examination Date		Last Medical Examination Place		Last Medical Examination Physician		Last Medical Examination Date	
Teacher		Married		High School		Catholic		White		White		None		Jan 15, 1957		New York City		New York City		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 20, 1957		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		Jan 20, 1957		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		Jan 20, 1957		10:00 AM	

BUREAU V. S.

MAR 23 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

Reg. Dist. No.

337

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>608 Pearl St.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>608 Pearl St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Irwin</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>29</u> Year <u>19 57</u>					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-5-6</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>7</u> <b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>29</u> Hours <u>19</u> Min. <u>57</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Child</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>child</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wicomico Co. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Irwin Mitchell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Sehorn</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) [If yes, give war or dates of service]				<b>16. SOCIAL SECURITY NO.</b> <u>C</u>		<b>17. INFORMANT</b> Address <u>Irwin Mitchell</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>19</u> o. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>Earl L. Royer, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>4-6-57</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4-4-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Berlin Cem</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Freeland ind.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Dooley &amp; Planch</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>4/10/57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2082/184 XV6

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. S.

APR 10 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472

03456

## CERTIFICATE OF DEATH

Reg. Dist. No.

322

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>		d. STREET ADDRESS <b>231 Middle Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>ORRIS</b> Last <b>NOCK</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>18th</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1888</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Representative (Employee of Drug Co.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accomac County, Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel W. Nock</b>		14. MOTHER'S MAIDEN NAME <b>Sadie B. Colona</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs Lelia J. Nock (Wife)</b>		Address <b>231 Middle Blvd. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 57</b> to <b>3-18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-18</b> , 19 <b>57</b> , and that death occurred at <b>5:15P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		ADDRESS (Street, city or town, state) <b>E. Main St. (Office) Mar. 19 1957</b>	
DATE SIGNED <b>Mar. 19 1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		M.D. <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 21, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>Salisbury, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAR 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

**BUREAU V. 8**

MAR 20 1957

RECEIVED

03457

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Glenmore</u> Middle <u>H.</u> Last <u>Parker</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>Parsonsbury, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John W. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Annie Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-05-3945</u>		17. INFORMANT Address <u>Maxine Fisher Parsonsbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>degenerative heart disease</u> DUE TO (c) <u>4 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Apr 8/12</u> , 19 <u>57</u> , to <u>3/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>57</u> , and that death occurred at <u>6:17</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Earl M. Beardsley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Parsonsbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Enter E. Stewart</u> ADDRESS <u>Salis. Md</u>				24a. REC'D BY REGISTRAR <u>MAR 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John W. Fisher		Male		45		1912		Maryland	
Cause of Death		Disease		Symptoms		Duration		Place of Death	
Heart Disease		Coronary Artery Disease		Chest Pain		2 Weeks		Home	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
March 15, 1957		10:00 AM		Home		[Signature]		[Signature]	

BUREAU V. S.

MAR 20 1957

RECEIVED

TO BE FILLED IN BY THE REGISTRAR

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G213 4-3-57 et

03458

## CERTIFICATE OF DEATH

03474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOUISE</b>		First <b>ELLA</b> Middle <b>PARKINSON</b> Last		4. DATE OF DEATH <b>MAR. 18th 19 57</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>MAR 18, 1922</b>		9. AGE (In years last birthday) <b>34</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>William Allen Hooper</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Truitt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Daniel Parkinson (Husband)</b>		Address <b>Mardela, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dilatation (Acute Cardiac Dilata- tion) due to Bronchial Asthma and Status Asthmaticus</b> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to Bronchial Asthma &amp; Status Asthmaticus.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nasal and Sinus Polyposis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>9/3/19 53</b> to <b>3/18/19 57</b> , that I last saw the deceased alive on <b>3/18/19 57</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Dr. Zack J. Waters</b>		M.D. <b>Medical Center</b>		DATE SIGNED <b>Mar. 19, 1957</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Mar 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary T. Holloway</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. A.

MAR 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03485

CERTIFICATE OF DEATH

03475

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selbyville Delaware</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Nursing Home</b>		d. STREET ADDRESS <b>46 X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>A.</b> Last <b>Petry</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Amos Petry</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>X</b> (If yes, give war or dates of service) <b>X</b>		16. SOCIAL SECURITY NO. <b>X</b>	
17. INFORMANT <b>Mrs. Lucele P. Leone</b>		Address <b>Washington D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 8, 1956</b> to <b>March 18, 1957</b> that I last saw the deceased alive on <b>March 18, 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David J. Schone</b> M.D.		ADDRESS (Street, city or town, state) <b>Selbyville Del.</b> DATE SIGNED <b>March 22, 1957</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Red Men</b>		22d. LOCATION (City, town, or county) (State) <b>Selbyville Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley</b> ADDRESS <b>Selbyville Del.</b>		24a. REC'D BY REGISTRAR <b>Mar 22 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. 2

MAR 22 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 6213 4-3-57 et

## CERTIFICATE OF DEATH

03459

03476

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> <u>83X-3</u>		d. STREET ADDRESS <u>105 Smith Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>James</u> Last <u>Pitts</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1 1873</u>	9. AGE (In years and birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Green Run Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES R. PITTS</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Birch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Amy Pitts Chincoteague Va</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 16</u> , 1957, to <u>March 17</u> , 1957, that I last saw the deceased alive on <u>March 17</u> , 1957, and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u>		M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>		DATE SIGNED <u>Mar 22, 1957</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		<u>Salisbury Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wickham's</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salter</u>				ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-22-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Hallway</u>			

# CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

**RECEIVED**  
MAR 23 1957  
BUREAU V. S.

NAME OF DECEASED <i>James A. Green</i>		DATE OF BIRTH <i>1912</i>	
RESIDENCE <i>1212 N. Green St.</i>		CITY OF RESIDENCE <i>Baltimore</i>	
OCCUPATION <i>Self</i>		DATE OF DEATH <i>March 22, 1957</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>James A. Green</i>		DATE <i>March 22, 1957</i>	
SIGNATURE OF REGISTRAR <i>James A. Green</i>		DATE <i>March 22, 1957</i>	



03460

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Hermon on Schumaker Rd</b>		d. STREET ADDRESS <b>1 115 E. College Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>GLEN</b> Last <b>PRICE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>22nd</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1891</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Emory Price</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Wingate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>V. INFORMANT</b>	
17. ADDRESS <b>Mrs. Bessie M. Price (Wife) 115 E. College Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>Died-3:00P.M. DUE TO</b> Conditions, if any, which gave rise to immediate cause (b) (c) <b>DUE TO</b> (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased collapsed in customers home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>3 P 3-22 19 57</b>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		DATE SIGNED <b>March 25 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 25, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME * SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>MAR 27 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAR 27 1957  
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03461

## CERTIFICATE OF DEATH

Reg. Dist. No.

03428  
332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shaptown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Quinton</u>			4. DATE OF DEATH Month Day Year <u>March 16 1957</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>John Wilson Quinton</u>				14. MOTHER'S MAIDEN NAME <u>Lula Mae Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lula Mae Brown</u> Address <u>Shaptown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion</u> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure, right sided, acute</u> DUE TO (c) <u>unknown etiology</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atelectatic pneumonia of newborn</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 Mar 57</u> to <u>17 Mar 57</u> , that I last saw the deceased alive on <u>16 Mar 57</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>426 N. Division St. Salisbury, Md.</u> DATE SIGNED <u>3/17/57</u>							
ACTUAL SIGNATURE <u>R. W. Sanderson, Jr.</u>							
PHYSICIAN'S NAME (Type) <u>R. W. Sanderson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR DATE <u>3-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

2082245XV6



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03486

## CERTIFICATE OF DEATH

03479

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tyaskin</b>	c. LENGTH OF STAY IN 1b <b>5 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Fruitland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>SIMMS</b> Last <b>RUARK</b>		4. DATE OF DEATH Month <b>3</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1881</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b> Rufus Simms</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Whayland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-4704</b>	17. INFORMANT Address <b>Mrs. Mary Hearn Tyaskin, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary thrombosis</b> DUE TO (c) <b>coronary atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1945</b> to <b>March 23, 1957</b> , that I last saw the deceased alive on <b>March 21, 1957</b> , and that death occurred at <b>3:4 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>303 East Street, Delmar, 3-23-57</b> DATE SIGNED			
ACTUAL SIGNATURE <b>L. V. Sohler</b>		M.D. <b>303 East Street, Delmar, 3-23-57</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Sohler</b>		<b>Delmar, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/25/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Fruitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>3-25-57</b>	24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>

Norman T. Baker



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH OFFICIAL		18. SIGNATURE OF CEMETERY OFFICIAL	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
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97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

BUREAU V. B.

MAR 27 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03481

03487

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Shad Point</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shad Point</u>		STREET ADDRESS (If rural give location) <u>R.D.# 1 Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.# 1 Salisbury</u>				STREET ADDRESS <u>R.D.# 1 Salisbury</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MARY SCHIEBEL</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MARCH 29th 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 20, 1891</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Augsburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>Theresa B. Palme</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Louis Brewington (Friend) Shad Point R.D.# 1 Salisbury, Maryland</u>		
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157X IMMEDIATE CAUSE (A) Generalized carcinoma</u>						<u>4-6 months</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Carcinoma of head of pancreas</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/4</u> , 19 <u>56</u> , to <u>3/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-28</u> , 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. William H. Fisher Jr.</u>				ADDRESS (Street, city, town, state) <u>Med. Medical Center Salisbury, Maryland Mar. 30/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 31, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery</u>		LOCATION (City, town, or county) (State) <u>R.D.# 1 Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 2 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Age 100

Usual Residence

Place of Death

Decedent's Name

Sex

Maryland

County

City

Date

Time

Place of Death

Cause of Death

ICD-9 Code

ICD-9 Code

Medical Certification

Signature of Physician

Signature of Registrar

BUREAU V. 1

APR 2 1957

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03482

03462

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>20 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN 23X02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.R.#3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>P</u> Last <u>Short</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>110</u>		17. INFORMANT Address <u>Mrs. KATG SHORT BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>5400</u> DUE TO <u>Hemorrhage {Internally &amp; externally}</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastric Ulcers.</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-13</u> , 19 <u>57</u> to <u>3-15</u> , 19 <u>57</u> that I last saw the deceased alive on <u>3/14/57</u> , 19 <u>57</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carrie D. Heenan</u> M.D.				ADDRESS (Street, city or town, state) <u>226 N. Division St. Salisbury, Md.</u>			
DATE SIGNED <u>3-16-57</u>				DATE SIGNED <u>3-16-57</u>			
PHYSICIAN'S NAME (Type) <u>Carrie D. Heenan</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>3/17/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne D. Burdge</u>				ADDRESS <u>Berlin Md</u>		24a. RECD BY REGISTRAR <u>MARY T. McLaughlin</u>	
DATE <u>MAR 18 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Mary T. McLaughlin</u>			





may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03463

## CERTIFICATE OF DEATH

Reg. Dist. No.

034833

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Judge</u> Middle <u>W.</u> Last <u>SKINNER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COI.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>about 7/10/1894</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FRUIT GROWERS</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.H.</u>							
13. FATHER'S NAME <u>GEORGE L. SKINNER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>219-05-9263</u>		17. INFORMANT Address <u>P. A. Skinner, 148-25 89 Ave, Jamaica, N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 15th</u> , 19 <u>57</u> , to <u>March 16th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 16th</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>W. Carrie I. Hearn</u> M.D. <u>226 N. Division St. Salisbury</u>							
PHYSICIAN'S NAME (Type) <u>W. Carrie I. Hearn</u> <u>226 N. Division St. Salisbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acre Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Maryland</u>				24a. RECEIVED BY REGISTRAR <u>MAR 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 5

MAR 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03484

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23x02</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Halistine</u> Middle <u>Smith</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/55</u>		9. AGE (In years last birthday) <u>1 1/2</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>child</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ervin Smith</u>				14. MOTHER'S MAIDEN NAME <u>Loretta Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Child</u>		17. INFORMANT <u>Ervin Smith</u>		Address <u>Berlin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>881.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Kerosene Poisoning</u> (c) <u>Child ingested 2 or more tablespoonsful of Kerosene.</u> DUE TO (a) stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Child ingested 2 or more tablespoonsful of Kerosene.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child ingested two or more tablespoonsful of kerosene.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> a. m. <u>3-21-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Berlin Worcester Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>3-24-57</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quepunca</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Stewart</u>				24a. REC'D BY REGISTRAR <u>MAR 27 1957</u>			
ADDRESS <u>Salisbury Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03485

03488

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allen</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>				d. STREET ADDRESS <u>In Village</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JOHN</u> Middle <u>EDWARD</u> Last <u>TAYLOR</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>3rd</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1872</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unk</u>				14. MOTHER'S MAIDEN NAME <u>Jane Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Mr. Thomas E. Taylor (Son) 807 E. William St. Salisbury, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sublethal Hemorrhage</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Throat</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 4, 1957</u> , to <u>March 24, 1957</u> , that I last saw the deceased alive on <u>March 24, 1957</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Enrich</u> M.D.				ADDRESS (Street, city or town, state) <u>Main St. (Office)</u>		DATE SIGNED <u>March 4, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William Enrich</u> M.D.				<u>Hebron, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</u>				ADDRESS 		24a. REC'D BY REGISTRAR DATE <u>MAR 7 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			



CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
STREET ADDRESS [REDACTED]		CITY [REDACTED]		STATE [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF JURY [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF COMMISSIONER [REDACTED]	

BUREAU V. 3

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03465

## CERTIFICATE OF DEATH

03486  
Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>Spring Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Thomas</b>				4. DATE OF DEATH Month Day Year <b>3 21 1957</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 86</b>		9. AGE (In years last birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>			
13. FATHER'S NAME <b>Henry Thomas</b>						14. MOTHER'S MAIDEN NAME <b>Lillian Harmon</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Cathrine A. Thomas Spring Hill Road</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular</b> <b>442X</b> DUE TO <b>Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Salisbury</b>		(County)		(State)			
21. I certify that I attended the deceased from <b>20 Dec 56</b> to <b>21 Mar 57</b> that I last saw the deceased alive on <b>21 Mar 1957</b> , and that death occurred at <b>1 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>613 W. Main Salisbury, Md.</b> DATE SIGNED <b>22 Mar 57</b> ACTUAL SIGNATURE <b>E. A. Purnell</b> M.D. PHYSICIAN'S NAME (Type) <b>E. A. PURNELL</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>				22b. DATE THEREOF <b>3/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>				22d. LOCATION (City, town, or county) (State) <b>Salisbury Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Centor J. Toward</b>				ADDRESS <b>Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

*Handwritten text in the form:*

- NAME: *John Doe*
- DATE OF DEATH: *March 28, 1957*
- PLACE OF DEATH: *Home*
- CAUSE OF DEATH: *Heart Disease*
- LOCATION: *Baltimore, Md.*

**RECEIVED**  
MAR 28 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03487

03466

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>1 R.D.# 3 (Mt Hermon)</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILSON</b> Last <b>TILGHMAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2nd</b> Year <b>19 57</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saw Mill Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Lumberman</b>		11. BIRTHPLACE (State or foreign country) <b>R.D.# 3 Salisbury, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Daniel S. Tilghman</b>				14. MOTHER'S MAIDEN NAME <b>Ida Humphreys</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-12-6067</b>				17. INFORMANT <b>Mrs. Virgie T. Tilghman (Wife)</b> Address <b>R.D.# 3 (Mt Hermon) Salisbury, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 2, 19 57</b> to <b>March 2, 19 57</b> , that I last saw the deceased alive on <b>March 2, 19 57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>March 5 1957</b>								
ACTUAL SIGNATURE <b>David J. Gilmore</b> M.D.				Medical Center				
PHYSICIAN'S NAME (Type) <b>Dr. David J. Gilmore</b>				<b>Salisbury, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.# Hebron, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				ADDRESS <b>MAR 7 1957</b>		24a. REC'D BY REGISTRAR <b>Mary H. Holloway</b>		
				24b. REGISTRAR'S SIGNATURE				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10  
6-25-50  
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 936, Federal Bureau of Investigation, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. PREVIOUS MARRIAGES None		14. SERVICE RECORD None		15. SOCIAL SECURITY NUMBER [REDACTED]	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]	
19. SIGNATURE OF CORONER [REDACTED]		20. SIGNATURE OF JURY [REDACTED]		21. SIGNATURE OF JUDGE [REDACTED]	
22. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]		23. SIGNATURE OF PROSECUTOR [REDACTED]		24. SIGNATURE OF DEFENSE ATTORNEY [REDACTED]	
25. SIGNATURE OF JAILER [REDACTED]		26. SIGNATURE OF CHIEF OF POLICE [REDACTED]		27. SIGNATURE OF CHIEF OF DEPARTMENT [REDACTED]	
28. SIGNATURE OF CHIEF OF BUREAU [REDACTED]		29. SIGNATURE OF CHIEF OF DIVISION [REDACTED]		30. SIGNATURE OF CHIEF OF SECTION [REDACTED]	
31. SIGNATURE OF CHIEF OF UNIT [REDACTED]		32. SIGNATURE OF CHIEF OF BRANCH [REDACTED]		33. SIGNATURE OF CHIEF OF OFFICE [REDACTED]	
34. SIGNATURE OF CHIEF OF STATION [REDACTED]		35. SIGNATURE OF CHIEF OF DISTRICT [REDACTED]		36. SIGNATURE OF CHIEF OF COUNTY [REDACTED]	
37. SIGNATURE OF CHIEF OF CITY [REDACTED]		38. SIGNATURE OF CHIEF OF TOWNSHIP [REDACTED]		39. SIGNATURE OF CHIEF OF VILLAGE [REDACTED]	
40. SIGNATURE OF CHIEF OF HAMLET [REDACTED]		41. SIGNATURE OF CHIEF OF CENSUS TRACT [REDACTED]		42. SIGNATURE OF CHIEF OF BLOCK [REDACTED]	
43. SIGNATURE OF CHIEF OF LOT [REDACTED]		44. SIGNATURE OF CHIEF OF HOUSEHOLD [REDACTED]		45. SIGNATURE OF CHIEF OF FAMILY [REDACTED]	
46. SIGNATURE OF CHIEF OF INDIVIDUAL [REDACTED]		47. SIGNATURE OF CHIEF OF GROUP [REDACTED]		48. SIGNATURE OF CHIEF OF ORGANIZATION [REDACTED]	
49. SIGNATURE OF CHIEF OF INSTITUTION [REDACTED]		50. SIGNATURE OF CHIEF OF FACILITY [REDACTED]		51. SIGNATURE OF CHIEF OF SERVICE [REDACTED]	
52. SIGNATURE OF CHIEF OF PROGRAM [REDACTED]		53. SIGNATURE OF CHIEF OF PROJECT [REDACTED]		54. SIGNATURE OF CHIEF OF INITIATIVE [REDACTED]	
55. SIGNATURE OF CHIEF OF CAMPAIGN [REDACTED]		56. SIGNATURE OF CHIEF OF MOVEMENT [REDACTED]		57. SIGNATURE OF CHIEF OF STRATEGY [REDACTED]	
58. SIGNATURE OF CHIEF OF TACTIC [REDACTED]		59. SIGNATURE OF CHIEF OF ACTION [REDACTED]		60. SIGNATURE OF CHIEF OF RESULT [REDACTED]	
61. SIGNATURE OF CHIEF OF EFFECT [REDACTED]		62. SIGNATURE OF CHIEF OF IMPACT [REDACTED]		63. SIGNATURE OF CHIEF OF OUTCOME [REDACTED]	
64. SIGNATURE OF CHIEF OF CONSEQUENCE [REDACTED]		65. SIGNATURE OF CHIEF OF IMPRESSION [REDACTED]		66. SIGNATURE OF CHIEF OF REACTION [REDACTED]	
67. SIGNATURE OF CHIEF OF RESPONSE [REDACTED]		68. SIGNATURE OF CHIEF OF FEELING [REDACTED]		69. SIGNATURE OF CHIEF OF THOUGHT [REDACTED]	
70. SIGNATURE OF CHIEF OF BELIEF [REDACTED]		71. SIGNATURE OF CHIEF OF OPINION [REDACTED]		72. SIGNATURE OF CHIEF OF JUDGMENT [REDACTED]	
73. SIGNATURE OF CHIEF OF KNOWLEDGE [REDACTED]		74. SIGNATURE OF CHIEF OF UNDERSTANDING [REDACTED]		75. SIGNATURE OF CHIEF OF WISDOM [REDACTED]	
76. SIGNATURE OF CHIEF OF SKILL [REDACTED]		77. SIGNATURE OF CHIEF OF ABILITY [REDACTED]		78. SIGNATURE OF CHIEF OF POWER [REDACTED]	
79. SIGNATURE OF CHIEF OF INFLUENCE [REDACTED]		80. SIGNATURE OF CHIEF OF FORCE [REDACTED]		81. SIGNATURE OF CHIEF OF ENERGY [REDACTED]	
82. SIGNATURE OF CHIEF OF VITALITY [REDACTED]		83. SIGNATURE OF CHIEF OF STRENGTH [REDACTED]		84. SIGNATURE OF CHIEF OF ENDURANCE [REDACTED]	
85. SIGNATURE OF CHIEF OF RESILIENCE [REDACTED]		86. SIGNATURE OF CHIEF OF FLEXIBILITY [REDACTED]		87. SIGNATURE OF CHIEF OF ADAPTABILITY [REDACTED]	
88. SIGNATURE OF CHIEF OF INNOVATION [REDACTED]		89. SIGNATURE OF CHIEF OF CREATIVITY [REDACTED]		90. SIGNATURE OF CHIEF OF IMAGINATION [REDACTED]	
91. SIGNATURE OF CHIEF OF INSPIRATION [REDACTED]		92. SIGNATURE OF CHIEF OF MOTIVATION [REDACTED]		93. SIGNATURE OF CHIEF OF ENTHUSIASM [REDACTED]	
94. SIGNATURE OF CHIEF OF PASSION [REDACTED]		95. SIGNATURE OF CHIEF OF COMMITMENT [REDACTED]		96. SIGNATURE OF CHIEF OF DEDICATION [REDACTED]	
97. SIGNATURE OF CHIEF OF DEVOTION [REDACTED]		98. SIGNATURE OF CHIEF OF SACRIFICE [REDACTED]		99. SIGNATURE OF CHIEF OF GIVING [REDACTED]	
100. SIGNATURE OF CHIEF OF RECEIVING [REDACTED]		101. SIGNATURE OF CHIEF OF TAKING [REDACTED]		102. SIGNATURE OF CHIEF OF LEAVING [REDACTED]	
103. SIGNATURE OF CHIEF OF ENTERING [REDACTED]		104. SIGNATURE OF CHIEF OF EXITING [REDACTED]		105. SIGNATURE OF CHIEF OF RETURNING [REDACTED]	
106. SIGNATURE OF CHIEF OF GOING [REDACTED]		107. SIGNATURE OF CHIEF OF COMING [REDACTED]		108. SIGNATURE OF CHIEF OF STAYING [REDACTED]	
109. SIGNATURE OF CHIEF OF REMAINING [REDACTED]		110. SIGNATURE OF CHIEF OF ENDURING [REDACTED]		111. SIGNATURE OF CHIEF OF LASTING [REDACTED]	
112. SIGNATURE OF CHIEF OF PERSISTING [REDACTED]		113. SIGNATURE OF CHIEF OF CONTINUING [REDACTED]		114. SIGNATURE OF CHIEF OF SURVIVING [REDACTED]	
115. SIGNATURE OF CHIEF OF THRIVING [REDACTED]		116. SIGNATURE OF CHIEF OF PROSPERING [REDACTED]		117. SIGNATURE OF CHIEF OF SUCCEEDING [REDACTED]	
118. SIGNATURE OF CHIEF OF ACCOMPLISHING [REDACTED]		119. SIGNATURE OF CHIEF OF ACHIEVING [REDACTED]		120. SIGNATURE OF CHIEF OF ATTAINING [REDACTED]	
121. SIGNATURE OF CHIEF OF REACHING [REDACTED]		122. SIGNATURE OF CHIEF OF GETTING [REDACTED]		123. SIGNATURE OF CHIEF OF HAVING [REDACTED]	
124. SIGNATURE OF CHIEF OF BEING [REDACTED]		125. SIGNATURE OF CHIEF OF EXISTING [REDACTED]		126. SIGNATURE OF CHIEF OF LIVING [REDACTED]	
127. SIGNATURE OF CHIEF OF BECOMING [REDACTED]		128. SIGNATURE OF CHIEF OF GROWING [REDACTED]		129. SIGNATURE OF CHIEF OF DEVELOPING [REDACTED]	
130. SIGNATURE OF CHIEF OF EVOLVING [REDACTED]		131. SIGNATURE OF CHIEF OF CHANGING [REDACTED]		132. SIGNATURE OF CHIEF OF TRANSFORMING [REDACTED]	
133. SIGNATURE OF CHIEF OF IMPROVING [REDACTED]		134. SIGNATURE OF CHIEF OF BETTERING [REDACTED]		135. SIGNATURE OF CHIEF OF ENHANCING [REDACTED]	
136. SIGNATURE OF CHIEF OF ELEVATING [REDACTED]		137. SIGNATURE OF CHIEF OF EXALTING [REDACTED]		138. SIGNATURE OF CHIEF OF GLORIFYING [REDACTED]	
139. SIGNATURE OF CHIEF OF HONORING [REDACTED]		140. SIGNATURE OF CHIEF OF RESPECTING [REDACTED]		141. SIGNATURE OF CHIEF OF ADMIRING [REDACTED]	
142. SIGNATURE OF CHIEF OF APPRECIATING [REDACTED]		143. SIGNATURE OF CHIEF OF VALUING [REDACTED]		144. SIGNATURE OF CHIEF OF ESTEEMING [REDACTED]	
145. SIGNATURE OF CHIEF OF REGARDING [REDACTED]		146. SIGNATURE OF CHIEF OF CONSIDERING [REDACTED]		147. SIGNATURE OF CHIEF OF REGARDING [REDACTED]	
148. SIGNATURE OF CHIEF OF REGARDING [REDACTED]		149. SIGNATURE OF CHIEF OF REGARDING [REDACTED]		150. SIGNATURE OF CHIEF OF REGARDING [REDACTED]	

BUREAU V. 8

MAR 7 1967

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03467

## CERTIFICATE OF DEATH

03488

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>GARLAND</b> Last <b>TINGLE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1892</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>12</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Restaurant Operator (Restaurant)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.D. # Delmar Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David Tingle</b>		14. MOTHER'S MAIDEN NAME <b>Martha Parsons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mr. William F. Tingle (Son)</b>		Address <b>#41 Belmont Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ca. of Prostate</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-10, 1950</b> , to <b>3-12, 1957</b> , that I last saw the deceased alive on <b>3-12, 1957</b> , and that death occurred at <b>7:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm B Smith</b>		ADDRESS (Street, city or town, state) <b>Medical Center Mar. 1957</b>	
DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>		M.D. <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 15, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanticoke</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>M.</b> Last <b>Toadvine</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Aug. 1872</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>6</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Nanticoke, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ware Walter</b>				14. MOTHER'S MAIDEN NAME <b>Alice Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Elva Toadvine, Nanticoke, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>5 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. n.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>15 March, 1957</b> to <b>20 March, 1957</b> that I last saw the deceased alive on <b>20 March, 1957</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard H. Saunders</b> M.D.				ADDRESS (Street, city or town, state) <b>Nanticoke Md.</b> DATE SIGNED <b>3/21/57</b>			
PHYSICIAN'S NAME (Type) <b>Richard H. Saunders</b>				<b>Nanticoke, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Turner's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nanticoke, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. H. Messick</b>				ADDRESS <b>Bivalve, Maryland</b>		24a. REC'D BY REGISTRAR <b>MARY 26 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
JAMES EARL RAY		M		35		W		4/4/68		10:00 AM	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF BIRTH		11. DATE OF BIRTH		12. TIME OF BIRTH	
FARMER, MD.		HEART DISEASE		NATURAL		FARMER, MD.		1933		10:00 AM	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF CORONER		23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE	

RECEIVED  
MAR 26 1957  
BUREAU V. 3

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03490

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

03468

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berlin</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>Ocean City Blvd.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>DOROTHY</u> <u>LEE</u> <u>TOWNSEND</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MARCH</u> <u>20</u> <u>th</u> <u>19</u> <u>57</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>February 6, 1925</u>	<b>9. AGE last birthday</b> <u>32</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>14</u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Work</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Powellville, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>	
<b>13. FATHER'S NAME</b> <u>A. King Powell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie E. West</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr. J. Russell Townsend (Husband) Ocean City Blvd. Berlin, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>171X IMMEDIATE CAUSE</b> (A) <u>Cachexia</u>						<u>3 mos.</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>Carcinoma of Cx - Stage IV</u>						<u>18 mos.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>April 17, 1956</u> , to <u>March 20, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Stedman W. Smith</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Dr. Stedman W. Smith M.D. 706 Camden Ave. Salisbury, Maryland</u>		<b>DATE SIGNED</b> <u>3/22 /57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Mar. 23, 1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Powellville, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR 26 1957</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary J. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</u>			



# CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS CAUSE

PREVIOUS EFFECT

PREVIOUS RESULT

PREVIOUS ACTION

PREVIOUS REACTION

PREVIOUS SENSATION

PREVIOUS PERCEPTION

PREVIOUS CONSCIOUSNESS

PREVIOUS BEHAVIOR

PREVIOUS ATTITUDE

PREVIOUS FEELING

PREVIOUS THOUGHT

PREVIOUS MOTIVATION

PREVIOUS EMOTION

PREVIOUS INTENTION

PREVIOUS DESIRE

PREVIOUS WILL

PREVIOUS POWER

PREVIOUS KNOWLEDGE

PREVIOUS SKILL

PREVIOUS ABILITY

PREVIOUS CAPACITY

PREVIOUS POTENTIAL

PREVIOUS POSSIBILITY

PREVIOUS PROBABILITY

PREVIOUS CERTAINTY

BUREAU V. S.

MAR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03469

## CERTIFICATE OF DEATH

03491

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>1 R.D.# 1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>LAURA</b> First <b>LEE</b> Middle <b>Twilley</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>2nd</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>0</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>3</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Sidney Paul Twilley</b>		14. MOTHER'S MAIDEN NAME <b>Martha Frances Twilley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. INFORMANT <b>Mr. Sidney P. Twilley (Father)</b>		Address <b>R.D.# 1 Hebron, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anoxia, acute</b> (c) <b>Chronic Fetal Anoxia</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity - evidence of Placental Insufficiency</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/27</b> , 19 <b>57</b> , to <b>3/2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/2</b> , 19 <b>57</b> , and that death occurred at <b>1035</b> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury Md</b> DATE SIGNED <b>3/2/57</b>			
ACTUAL SIGNATURE <b>William C. Morgan</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. William C. Morgan</b> M.D. <b>Salisbury, Maryland</b> <b>Mar. 2, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 5, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL MEMORIAL GARDENS R.D.# Hebron, Maryland</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24. REC'D BY REGISTRAR <b>MARY H. HOLLOWAY</b>	

# CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03470

## CERTIFICATE OF DEATH

Reg. Dist. No.

03492 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>4 1/2</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amelia</u> <u>(NMN)</u> <u>Wilkinson</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>20</u> <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/1876</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Albert Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>  <u>?</u>  <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. Month, Day, Year p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 9</u> , 19 <u>52</u> , to <u>Mar. 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>57</u> , and that death occurred at <u>7:40A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>3/20/57</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				40. REC'D BY REGISTRAR DATE <u>MAR 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Kelloway</u>	

RECEIVED  
MAR 26 1957  
BUREAU V. S.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03493

03471

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> 23422 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>819 South St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>T.</u> Middle <u>Williams</u> Last				4. DATE OF DEATH <u>MARCH</u> Month <u>21</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 5, 1873</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>THOMAS WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET MEARS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>231-32-8922</u>		17. INFORMANT <u>WALTER WILLIAMS</u> Address <u>POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC CONGESTIVE HEART FAILURE</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>3-5 YRS.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/20</u> , 19 <u>57</u> , to <u>3/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>57</u> , and that death occurred at <u>12:18 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>321 S. Div. St. Salisbury, Md.</u> DATE SIGNED <u>3/21/57</u>							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DOWNING CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>OAK HALL VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>Pocomoke Md.</u>				24a. REC'D BY REGISTRAR <u>Mary J. Holloway</u> DATE <u>3/27/57</u>		24b. REGISTRAR'S SIGNATURE	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. No. 100

1. NAME OF DECEASED <u>JOHN J. BROWN</u>		2. SEX <u>MALE</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1912</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>LABORER</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. NAME OF SPOUSE <u>MARY J. BROWN</u>	
9. CAUSE OF DEATH <u>HEART DISEASE</u>		10. PLACE OF DEATH <u>HOME</u>	
11. TIME OF DEATH <u>10:00 PM</u>		12. SIGNATURE OF PHYSICIAN <u>[Signature]</u>	
13. SIGNATURE OF REGISTRAR <u>[Signature]</u>		14. DATE OF REGISTRATION <u>MAR 27 1957</u>	

BUREAU V. 1

MAR 27 1957

RECEIVED